ST. BARTHOLOMEW'S HOSPITAL JOURNAL

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EDITORIAL

Barts are once more in the final of the Inter-Hospitals Rugby Cup, for the second time in four years. This time we play St. Mary's Hospital. It would have been pleasant to have revenge against the London Hospital for our defeat in 1955, but let us hope that Mary's will be crushed by our gallant and fighting fifteen, in the same way that Guy's and St. Thomas's were in the earlier rounds.

Rugby football has been the most prestigious sport at the London Medical Schools for many years now. Not only does it attract more players than the other sports, but also more supporters, even among those who scarcely know how the game is played. It is not so difficult to see why this should be so, for Rugby typifies the robust attitude to life, the rough and usually fair give-and-take, which is found more in medical students and doctors than in other walks of life. The battling spirit of a winning team even infects its supporters, and this has lead to breaches of the peace in the past, which it is hoped will be avoided on March 18th and during the week before. It is hard to see what inspiration would be derived by the team from the wearing, by a lady supporter, of salmon pink tights. Even less encouragement is given by the painting of slogans and other such destructive activities, which only serve to attract justified criticism—and bills.

However, there is always Percy cheering on the touch-line, and those who take it upon themselves to defend him do a great job. Unfortunately the magnificent figure of Percy tends to excite the animosity of our opponents' supporters, and riotous behaviour in his part of the field may follow. We hope it was not his defenders whom *The Times* rugby correspondent referred to when he wrote of hooligans at Inter-Hospital Rugby Cup matches. If it was, then he was being most unjust, and not a little unrealistic. One cannot expect our supporters to view the game as objectively as a sports writer does, nor can one expect enthusiastic young men to remain as impassive as Chelsea Pensioners at Stamford Bridge. So long as property and neutral non-belligerents are respected, rumbustious support is a natural and a good thing.

So now let us just keep our fingers crossed until the 18th, and hope that no-one is idiotic enough to start throwing paint and dye around, but that our team and its supporters carry the day.

CALENDAR

MARCH

Tues. 3—Squash *v* I.C.I. (**H**)
Wed. 4—Soccer *v* R.N.C. Greenwich (**A**)
Squash *v* Escorts (**H**)
Sat. 7—Dr. R. Bodley Scott on duty
Mr. A. H. Hunt on duty
Mr. F. T. Evans on duty
Rugger *v* Loughborough College (**A**)
Hockey *v* Inland Revenue (**H**)
Ladies' Hockey *v* Charing Cross (**H**)
Sun. 8—Hockey *v* Past Barts (**H**)
Tues. 10—Squash *v* St. Georges Hospital
Wed. 11—Soccer *v* R. Dental and Charing Cross
Sat. 14—Dr. A. W. Spence on duty
Mr. C. Naunton Morgan on duty
Mr. R. A. Bowen on duty
Rugger *v* Old Askeans (**H**)
Soccer *v* Caledonians (**H**)
Hockey *v* Oxted (**H**)
Tues. 17—Squash. Staff Match (**H**)
Sat. 21—Dr. G. Hayward on duty
Mr. A. W. Badenoch on duty
Mr. R. W. Ballantine on duty
Rugger *v* Aldershot Services (**A**)
Soccer *v* Swiss Mercantile College (**H**)
Hockey *v* K.C.H. (**A**)
Head of the River Race
Wed. 25—Final of the Inter Hospital Rugger Cup
Sat. 28—Dr. E. R. Cullinan on duty
Mr. J. P. Hosford on duty
Mr. C. Langton Hewer on duty

APRIL

Sat. 4—Medical and Surgical Unit on duty
Mr. G. H. Ellis on duty
Rugger Inter Firm Seven-a-Sides Chislehurst.

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Students' Union

Students' Council meeting on January 14th.

The principal matters discussed at this meeting were the travel expenses of students, the film society, and the appointment of a Publicity Officer to the Students' Union.

Mr. R. Willoughby had raised the question of travel expenses at the A.G.M., pointing out that they were refunded when students went to Hill End and to Bethnal Green on the Child Health Course. The matter had now coursed through the proper channel and the council were presented with the Dean's reply, which stated that the amount spent on these visits averaged 5d. per week per student during his clinical years, and that travel expenses were allowed for in Students' Grants, and that therefore there was no need to change the present system. The Council decided that another letter should be written to the Dean in the hope that the matter would be brought before the College Committee.

Mr. Padfield reported on the foundation of the new Film Society, with a membership fee of 2s., and a "contribution to the hire of films" of about 1s. 6d. for each performance. Members of the society automatically become Associate Members of the National Film Theatre.

The President, Mr. A. H. Hunt, suggested that there should be an elected Publicity Officer to organize and co-ordinate the publicity of the student clubs and societies. It was agreed that candidates for such a post should be advertised for.

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Abernethian Society

A very interesting meeting on "Alcoholism" was held in the Physiological Lecture Theatre on Thursday, January 13th. Three anonymous alcoholics first answered questions on their experiences. They told us how they had slowly progressed from occasional drunkenness to being constantly "tanked-up", starting the day with half-a-bottle of whisky before breakfast, and staying at that level of intoxication for days or weeks. We were also told about the organization and methods of working of "alcoholics anonymous". The first of the rules of this group is that its members are always alcoholics, and therefore that they must drink nothing, or the lot. It was particularly interesting that most of the other eleven rules were of a religious nature, though it was stressed that being an alcoholic was the only criterion for membership. It was at this point that a worried voice from the back asked for their

telephone number.

When Dr. Glatt of the Warlingham Park Hospital, the speaker for the evening, arrived, he gave a short account of the aetiology, course, and effects of alcoholism, then showed a short film about some methylated spirit drinkers, and finished by talking about the treatment. It was striking that the most effective treatment seems to be group psychotherapy largely organised by the patients themselves, and it is pleasant to think of a disease being made curable by its own sufferers.

There are two meetings in March. At the first, on the 10th, at 5.45 p.m., in the Physiology Lecture Theatre, Professor Thonemann from Harwell, the leader of the group working on the problems of controlling the energy from thermonuclear reactions, will be talking about their brain-child, " Zeta".

At the second at the same time and place on the 19th of the month Lord Evans, the Queen's Physician, will give a talk entitled " Bedside Bias."

Coming shortly, a lecture by Dr. Fuchs, of the Antarctic, and a combined meeting with the Royal College of Surgeons.

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Christian Union

Mr. A. S. Aldis (Assistant Director of the Welsh Surgical Unit) discussed the possibilities of Escapism or Reality with reference to Christianity in a talk on January 30th. The content of this talk was based rather on the significance of the idea of escapism than on the idea of reality. He opened by announcing that for those who regard religion as a simple excuse to free them from the cares of the world, he had no patience. The sufferings of St. Paul, of the many men and women who throughout the centuries have paid dearly for their faith in things unseen can hardly be regarded as such an escapism, and this surely is a lesson we should have learnt from the sufferings of Christ Himself. The blackness of the eighteenth century impresses itself on the imagination for its revelling and drunkenness, the intoxicated state of Members of Parliament and University dons, the existence of child labour and of slaves—which all occurred during a time when Christianity existed only in a most diluted form (though one may perhaps not consider this to be relevant: after all, wars and persecutions have also been associated with Christianity). The tide turned with the nation-wide preaching of Wesley: soon slave labour was abolished, and so, later, was child labour. Surely, Mr. Aldis pointed out, this is an indication to us of the necessity of Christianity to govern our lives; it is certainly no escapism, unless, of course, we mean an escape from human bondage to the liberty of the sons of God. He drew an analogy between the liberation of a prisoner by his own men, and the Escape prepared for *us* by the one Man, Christ. We would be most unwise, he suggested, not to avail ourselves of such an opportunity to escape when it is offered to us.

It was an interesting talk, but it seemed a pity that Mr. Aldis did not delve more deeply into the " Reality " aspect of the problem, perhaps, rather an unfortunate gap, for one rather felt that many of the audience had come to hear him expound on why Christianity is a reality, and not just why it is not escapism. Less discussion followed than might have been hoped, but the fact that the meeting was so well attended was certainly an indication of the very extensive interest taken in such problems, and we welcome further opportunities to hear the views of others and to air our own opinions.

Professor Sir James Paterson Ross was in the Chair, and was, he told us, pleased to have been asked, and even more so that he was able to receive and introduce to us Mr. Aldis.

P.J.W.

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Film Society

Amongst the large number of people who attended the first meeting of the Film Society, there must have been a few who wondered why this sort of function had not been attempted before. Although, of course, it is impossible to judge the total response on one meeting, the presence of over two hundred people indicates a good prognosis.

The Society held their first meeting on Monday, January 19th, at 8.30 p.m., in the Physiology Lecture Theatre at Charterhouse Square. Unfortunately, the film originally

billed, Hitchcock's " The Lady Vanishes", was delayed by snow in Scotland. However, we were offered " The Thirty-Nine Steps," Hitchcock's version of the famous Buchan novel. This, the main feature, was preceded by three short films: a shadow cartoon by Lottie Reiniger, a vintage Count Basie, and Walt Disney's " The Three Little Pigs."

Altogether, the programme was received very well and everyone appeared to enjoy the evening.

The Thirty-Nine Steps " was an early Hitchcock thriller, starring Robert Donat as Richard Hannay and showing Peggy Ashcroft in a small supporting role, an interesting experience in view of her recent successes. The celluloid was scratched and the sound-track was rather worn but some deterioration in quality is to be expected from an old film. The only fair criticism that could be made is that the screen was too small. Possible remedies to this situation are under investigation. In fact, after the initial minutes, very few people could have been bothered about it.

The formation and setting in motion of the Film Society was no small job and all credit is due to A. Padfield, who, with the invaluable help and expert advice of Dr. D. A. MacDonald, has seen the project through from the original germ-seed.

The Society is to run fortnightly shows throughout the winter, with the possibility of some in the summer too, and aims to mix popular appeal with a spree of especial interest and/or culture !

R. M. DRAKE.

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Matron's Ball

At 9 p.m. on January 7th the first couples arrived at Grosvenor House for Matron's Ball. At 2 a.m. the following day the last couples left. In the intervening five hours the four hundred nurses who were Matron's guests and the four hundred men who were Matron's and the nurses guests revelled themselves to a standstill to the excellent music of Sydney Lipton and his band, and the splendid feast served with the accustomed rapid efficiency of the Grosvenor waiters. The *Journal's* correspondent was too busy to notice everything that occurred but he received a strong impression that everyone enjoyed themselves and the good spirits of Christmastime were by no means dimmed. The band played too many South American airs for his own taste or accomplishments but apart from that nothing could be faulted. The ladies shone unrecognizably in their evening garb, while the gentlemen—well, they looked like gentlemen.

Our very sincere thanks we extend to our Governors for providing us with a first-class Ball, and to all those who organized it so efficiently.

View Day Ball

The View Day Ball this year returns to its habitat of a few years ago ; The Royal Festival Hall. It will take place as usual on the Friday after View Day, that is to say, May 15th.

It was at first hoped to hold the ball on the lawn at College Hall, but the arrangements for this could not be fully worked in time for this year's ball. There is, however, every expectation that it will be held there next year.

It was also suggested that the ball might be held on View Day itself, but this idea was abandoned when it was realised what effect a mid-week ball could have on the running of the hospital !

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Journal

Q. Why is the Journal not better than it is, or not as good as it was?

A. Because you Sir or Madam have not written up that interesting case you saw in the Accident Box, Wards, Out-Patients or elsewhere. Because that seed of a funny story has been left unsown. Because you haven't been asked to write anything.

Unsolicited articles for the Journal will be welcomed by the Editor who can be found at the Journal desk in the Library most days, and at the Special Treatment Centre on Fridays between 12 noon and 1 p.m. If he's not in just leave your article on the desk.

It has been pointed out that in the " 50 years ago " item in the February Journal the present generation of students may not know that W. G. Ball became Sir Girling, and T. J. Horder became Lord Horder. May the contributors of today and tomorrow advance to equal fame.

OBITUARY

A. D. WALL, F.R.C.S.

Many of his contemporaries will be sorry to hear of the death of A. W. Wall, " Fatty " to his friends. He came to Bart's from Oundle during the first World War, and after passing his 2nd, M.B., London, and gaining both junior and senior scholarships in anatomy and physiology, joined the R.N.V.R. as a surgeon probationer. He was in a destroyer at the battle of Jutland. After the Armistice, he qualified and gained his M.B., B.S., in 1919, and the F.R.C.S., in 1921. A keen, tough and energetic forward he was in the pack in the final of the Hospital Cup against Guy's in 1919-20, when the game was watched by King George V.

He was H.S. to the surgical unit under Professor Gask, and later to the E.N.T. department. He continued to serve the latter as a clinical assistant while he was junior Demonstrator of Pathology and later married the blue belt to the department, Peggy McGregor. Deciding to practise abroad he joined the M. firm in Shanghai as a surgeon and specialist in E.N.T. They were very happy there and would have stayed on to a normal retiring age if events in China had not dictated otherwise and forced them to give up at the outbreak of the second World War. In this he served in the R.A.M.C. as surgical specialist, saw active service in Narvik, Salerno and Crete (where he was mentioned in despatches) and landed in France with a military hospital on D. Day plus 5.

He returned to Paignton, where he had decided to practise, was appointed to the hospital and at his death was the senior surgeon. It was his great sorrow that as President of the Torbay Medical Society, and having invited Mr. Rupert Corbett as Guest of Honour at the Annual Dinner, he was by then too ill to attend.

" Fatty " was a staunch and loyal friend with a great sense of humour. The writer can remember many happy trips to the Broads in the early 1920's with mixed parties of Bart's and Thomas's men when he was always a live member of the party and great deeds were done.

He was much beloved in Paignton and there have been delightful tributes to his work there, in the journals.

To his widow and two daughters goes our sympathy in the loss of a devoted and kindly husband and father.

F.C.W.C.

NOTICES

Changes of Address

DR. D. A. O. CAIRNS:
" Shortlands", East Albany Road, Seaford, Sussex.

MR. C. GORDON SINCLAIR, F.R.C.S. :
" Redroofs", Cromwell Crescent, Worcester. Tel.: Worcester 2106.

Honoured

Ivan de Burgh Daly, lately Director of the Institute of Animal Physiology, Babraham, Cambridge, has been awarded the C.B.E.

Forthcoming Lecture

Mr. G. J. Hadfield of the Surgical Unit has been elected a Hunterian Professor at the Royal College of Surgeons. He will be giving a lecture entitled: " Hormone deprivation in Breast Cancer spontaneously arising or Surgically produced." The lecture is at the Royal College of Surgeons Lincoln's Inn Fields on Friday, May 1st, at 5 p.m. All students are welcome to attend.

University of London

Two graduates of St. Bartholomew's Hospital were elected to the two vacancies in Medicine on the Standing Committee of Convocation at the January meeting of Convocation held in Senate House.

Dr. N. A. Thorne, M.D. B.S., who topped the poll in Medicine, has been on Standing Committee since 1950, was Deputy Bedell and later Bedell of Convocation. He is consultant dermatologist to several London hospitals and lecturer on dermatology to the North London Postgraduate Medical Institute.

Dr. H. W. Bunje, who was also elected, is a newcomer to Standing Committee. He is a former medical chief assistant of Barts., and is now physician and scientific officer to the Medical Research Council.

Adviser in General Practice

Dr. T. O. McKane, of Dunmow, Essex, has succeeded Dr. G. F. Abercrombie as Adviser in General Practice at the Medical College. Dr. McKane is a member of the Northern Home Counties Faculty Board, and Honorary Secretary of the Undergraduate Education Committee of the Council of the College of General Practitioners.

ANNOUNCEMENTS

Marriages

CHALSTREY—BAYES.—On September 6th, 1958, Dr. Leonard John Chalstrey to Aileen Beatrice Bayes.

REESE—TURNER.—On January 24th, at St. Bartholomew-the-Less, Alan John Morris Reese to Margaret Denise Turner.

TABOR—WHITE.—On November 8th, 1958, Dr. Arthur S. Tabor to Dr. Shiona J. White.

Births

BIDDELL.—On January 8th, to Sheelagh, wife of Dr. P. B. Biddell, a daughter (Judith Mary).

CHITHAM.—On January 5th, to Heather, wife of Dr. R. G. Chitham, a daughter.

GILKS.—On January 19th, at c/o Pladju, South Sumatra, to June, wife of Dr. J. M. L. Gilks, a son.

GOODE.—On January 15th, to Patricia, wife of Dr. Howard Goode, a daughter (Geraldine Fiona).

HAYES.—On January 22nd, to Daphne, wife of Dr. Stuart Hayes, a daughter.

MACADAM.—On January 11th, in Buenos Aires, to Diana, wife of Dr. F. I. Macadam, a son (Andrew Joseph).

MACFARLANE.—On January 17th, to Moira, wife of David A. Macfarlane, M.Ch., F.R.C.S., a brother for Rosalie, Jane and Peter.

MERCER.—On November 28th, 1958, to Dr. and Mrs. M. H. Mercer, a daughter (Lucy Elizabeth), a sister for Nigel and Nicholas.

Deaths

CARSBERG.—On January 18th, Alfred Ernest Carsberg, M.A., M.D. (Cantab.) Qualified 1898.

CORBEN.—On January 15th, Charles Corben, M.D., F.R.C.S., Qualified 1893.

FELL.—On January 28th, Sir Matthew H. G. Fell, K.C.B., C.M.G., F.R.C.S. Qualified 1898.

OXLEY.—On January 28th, William Henry Francis Oxley, M.R.C.S., L.R.C.P., F.R.C.O.G., aged 82. Qualified 1897.

ROBINSON.—On December 6th, Dr. James Albert Robinson. Qualified 1915.

STUART.—On January 9th, Dr. Richard Stuart, Qualified 1925.

TOWNSEND.—On January 17th, Col. Reginald Stephen Townsend, M.C., M.D., M.R.C.O.G. Qualified 1907.

CANDID CAMERA

"Forgive us our trespasses . . . ."

INTESTINAL FAILURE

(a case of Malabsorption Syndrome)

by **J. TREVOR SILVERSTONE**

Introduction

The following case of malabsorption is unusual in that the patient developed multiple nutritional deficiences following a series of operations for recurrent peptic ulceration.

As full investigation of the underlying defects in the gastro-intestinal tract was necessary before rational treatment could be instituted, this aspect has to be considered in some detail. It thus provides an instructive example of some practical applications of chemical pathology.

Presentation

Mr. R., a warehouseman, aged 58, was admitted to Smithfield Ward under the care of Dr. Hayward, on 15th April, 1958, complaining of general ill-health, exertional dyspnoea, the passage of frequent (up to 20 per day) ' golden ' bulky stools, and swelling of the legs, abdomen, face and hands.

History

There was a long and involved history of gastro-intestinal symptoms with intermittent oedema. A summary is given below.

1924.—Perforated duodenal ulcer. Gastro jejunostomy performed. Following this had frequent episodes of mild peptic pain.

1936.—Oedema of both legs.

1937.—Haematemesis. Treated conservatively.

1943.—Jejunal ulcer diagnosed after passing melaena stools. Pitting oedema noticed on both legs extending to abdomen.

1944-1945.—Two episodes of oedema of legs associated with ascites.

1949.—Epigastric pain. Ulcer seen on X-ray. Bilateral vagotomy performed.

1953.—Very severe abdominal pain. Only temporary relief by rest and alkalis. Recurrence of gastric ulcer seen on X-ray. Admitted to Percival Pott Ward where a partial gastrectomy of the Polya type was performed by Mr. Kinmonth. At operation the ulcer was found to be penetrating into the pancreas. The bare area on the pancreas was cauterized.

During convalescence from this operation he began to pass bulky, malodorous stools several times a day. Shortly afterwards he noticed swelling of his legs, hands and face.

1954.—Gross oedema of all four limbs and face, plus marked exertional dyspnoea. Admitted to Bethnal Green Hospital. Investigations showed fatty stools with impaired fat absorption, a very low plasma albumin level (1.4 gm./100 ml.), lack of trypsin in duodenal juice. On the basis of these results he was given multiple replacement therapy. (Pancreatin, vitamins A, B, C, D and K, testosterone implant, and iron). He was placed on a high protein, low-fat diet. He remained symptom free for three years and returned to work. His plasma albumin rose to 4.0 gm./100 ml. and his weight was 9 st. 5 lb.

1958 (Present admission).—He had the following symptoms relating to malabsorption of:

(a) *Erythropoietic factors*—dyspnoea on minimal exertion.
(b) *Protein*—oedema of both legs.
(c) *Fats*—frequent bowel action (up to 20 times per day), ' golden ' foul-smelling stools which frequently contained recognizable food particles.
(d) *Vitamins*—
  (i) Sore throat and tongue for seven weeks prior to admission.
  (ii) Scaly red patches on the front of both shins coming on in the previous three weeks (suggestive of pellagra).
  (iii) Tingling and numbness in both feet together with pain in both shins, insteps, and in the fingers.

Other symptoms: a poor stream on micturition and nocturia (twice per night). (The nocturia might have been related to his malabsorption syndrome, as there is commonly a reversal of the diurnal rhythm of micturition).

P.H. Congestion left lung in childhood.

1917—Varicocoele.
1954—Haemorrhoidectomy.
He did not begin to shave until he was twenty six.

F.H. Father died of peritonitis following perforated peptic ulcer.
One younger brother had partial gastrectomy for D.U.
Seven children a/w.

S.H. Drank 3-4 pints Guinness and 1-2 whiskeys every night.
Smoked about 20 cigarettes per day.

Examination

The patient appeared pale and bloated. Compared with 1953 his appearance had become eunuchoid, with fine facial hair and sparse axillary and pubic hair.

Head and neck—the fundi were normal and the visual fields full. The tongue was smooth, and red at the tip and sides with prominent circumvallate papillae.

Respiratory system—n.a.d.

Cardiovascular system—Pulse regular, B.P. 140/90. A soft mid-systolic murmur was heard at the aortic area. Otherwise normal.

Abdomen—The abdomen was distended. There were four epigastric scars and a small incisional hernia was present in one of them. The liver was enlarged, being 5 finger breadths below the costal margin on deep inspiration. The edge was firm. Ascites was not present. There was no jaundice, spider naevi or palmar blush.

P.R. The rectum felt capacious. The prostate was not enlarged.

Uro-Genital system—The testicles felt small.

Nervous system—Diminished sensation to light touch and pin prick over both skins. Muscle tenderness in both calves. Tone, power, co-ordination and reflexes normal.

Limbs—Ankle oedema. (The extent of oedema varied and at one time involved the whole of both legs.) There was an area of bright red scaling over the shins of both legs; this was not tender.

Small ecchymoses were seen on both arms after the venous return had been occluded.

Investigations

In order to discover the exact nutritional deficiencies, the underlying defect in the gastro-intestinal tract and the degree and type of anaemia, several investigations were necessary:

(a) To determine the degree of malabsorption:

The deficiencies in absorption of various constituents of the diet are listed in Table II.

A barium meal and follow through showed the usual rapid emptying via the stoma. There was a tendency to dilation and feathery outline of one upper jejunal loop. No flocculation or segmentation. The rest of the small bowel filled normally.

Conclusion.—There was marked malabsorption of fat, protein, erythropoietic factors and vitamins, due in part to disturbance of the small intestine itself.

(b) To determine the degree of pancreatic insufficiency:

X-ray of abdomen revealed no calculi in the pancreatic region.

Glucose tolerance test—normal.

Starch tolerance test—flat curve, showing probably impaired digestion.

Duodenal intubation—no trypsin (gelatin was not liquified by a dilution of 1 in 25 of duodenal juice).

Protein fibres were seen in the stool.

Vitamin A absorption was nil (a reflection of diminished absorption of fats.)

Conclusion.—The poor absorption of starch as compared to the normal absorption of glucose points to a reduction in pancreatic amylase; the low vitamin A and fat absorption is due partly to a reduced pancreatic lipase. The low trypsin level in the duodenal juice completes the biochemical picture of pancreatic insufficiency.

(c) To determine the state of liver function:

(i) Plasma protein synthesis:
Total plasma proteins 4.6 g/100 ml. (normal—6.8 g/100 ml.)
Plasma albumin 2.4 g/100 ml. (normal—4-5.5 g/100 ml.)
Plasma globulins 2.2 g/100 ml. (normal—1.5-3 g/100 ml.)
Electrophoretic pattern—normal.
Flocculation tests:
Thymol turbidity 4 units (normal—1-4 units)
Zinc sulphate turbidity 7 units (normal 4-8 units)

(ii) Excretory function:
Alkaline phosphatase 10 King-

Endocrine Glands	Investigation	Remarks
PITUITARY	Skull X-ray: no erosion of Pituitary fossa Visual fields: normal	No large tumour of the pituitary No tumour involving the optic chiasm
THYROID	Basal metabolic rate: ± 0 per cent Protein bound iodine: 2.7 μg/100 ml. (normal: 4-8 ug/100 ml.) Serum cholesterol: 150 mg/100 ml. (normal for male aged 58: 220-300 mg/100 ml.)	Most reliable evidence of euthyroid state The low level is probably related to the malnutrition
ADRENAL CORTEX	Serum sodium: 140 meq/L (normal 135-150 meq/L) Serum potassium: 4.5 meq/L (normal 3.6-5.3 meq/L)	These normal values would be evidence against inadequacy of the adrenal cortex
+TESTIS	24 hr. Urinary 17-Ketosteroids: 3 mg (normal for male aged 58: 5-10 mg) 24 hr. Urinary 17-ketogenic steroids: 8 mg (normal 10-15 mg, but 8 mg not considered abnormal) 24 hr. urinary 17-Hydroxy-steroids: 10.5 mg (normal 10-15 mg)	The low level is probably related to: (1) Malnutrition (2) Testicular hypofunction (a) History of not shaving until 26 (b) Other adrenal steroids normal
PANCREATIC ISLET CELLS	Glucose Tolerance Test: normal	

Table I

Armstrong units (normal—4-13 units)
Bromsulphthalein excretion—23 per cent remained in the blood 45 mins. after injection of 300 mg. (This shows impairment in the ability of the liver to excrete this substance.)

(iii) Serum enzymes:
Pseudocholinesterase 14 units (normal—55 and above)
Glutamic—Oxaloacetic transaminase 38 units (normal—up to 40 units)
Glutamic—Pyruvate transaminase 40 units (normal—up to 40 units)
(The serum pseudocholinestomse is lowered in severe malnutrition, and is a reflection in this case, of reduced protein absorption).

Conclusion.—The low pseudocholinesterase and reduced bromsulphthalein excretion indicate a slight degree of liver malfunction which appeared insufficient to account for the low plasma albumin on the basis of reduced synthesis in the liver. The low albumin is probably due to malabsorption of dietary protein.

(d) To determine the endocrine basis

for testicular atrophy:

These tests and their significance are summarised in Table I.

Conclusion.—The testicular atrophy is a result of primary dysfunction of the testes, and is not secondary to disease in any other endocrine gland. However, the low 17 Ketosteroid level may well be a consequence of the malnutrition.

(e) To determine the degree and type of anaemia:

The haemoglobin level was 64 per cent of normal.

As can be seen in Table III there was macrocytosis (MCV 110c*u.*) associated with an iron deficiency (MCHC 29 per cent)—a so-called "biphasic" type of anaemia due to lack of erythropoietic factors and iron.

Conclusion.—The vitamin B12 deficiency was due to malfunction of the intestinal mucosa rather than due to lack of intrinsic factor, because the absorption of radioactive B12 remained low even when intrinsic factor was added.

(f) To exclude disease in other organs:

Urine—no albumin
sterile on culture
Stool—no occult blood
no pathogens, no cysts, no amoebae.
Blood urea—28 mgm/100 ml. (normal—20-40 mgm/100 ml.)
Erythrocyte sedimentation rate—8 mm. in 1 hr. (normal 0-10 mm/hr.)
Chest X-ray—normal
Serum acid phosphates—0.8 King-Armstrong units 100 ml. (normal—0.3-3 K.A. units/100 ml.)
W.R.—negative.

Diagnosis

On the basis of the history, clinical picture and pathological findings, a diagnosis of steatorrhoea, hypoproteinaemia, anaemia and multiple vitamin deficiency was made. Complicating factors were a degree of liver damage and testicular atrophy. The liver damage was possibly related to a high alcohol consumption and a reduced absorption of protein.

The differential diagnosis of the steatorrhoea and consequent malabsorption rested between idiopathic steatorrhea (also called adult coeliac disease, Cooke, 1958), pancreatic insufficiency, and post-gastrectomy syndrome. The relevant findings are listed in Table II where a comparative chart is drawn up. It can be seen that the features of the present case do not correspond exactly to any of the above diseases. It would seem that there was a major degree of pancreatic insufficiency (the result of fibrosis around the ulcer and unavoidable trauma at partial gastrectomy). In addition there was probably a change in the bacterial flora of the blind loop of duodenum and intestine formed during the gastrectomy.

Course and Treatment

As the various deficiencies of nutrition came to light appropriate replacement was made. This led to alleviation of the relevant symptoms and signs. Eventually the patient was receiving comprehensive replacement therapy consisting of the following:

(a) Diet—A high protein (120 g.) diet.
(b) Vitamins—Caps. Vit. A and D: t.d.s.
Tabs Ascorbic acid 100 mg. t.d.s.
Tabs Folic acid 10 mg. b.d.
Vit. B12 1,000 *ug* monthly.
(c) Minerals—Pot. chlor. 2G. t.d.s.
Tabs Calcium gluconate 2 t.d.s.
(d) Pancreatic enzymes—Pancreatin granules 2 measures (6 g.)
mixed with food.
(e) Antibiotics to sterilise the blind loop—Tetracycline 250 mgm. 12 hourly.
(f) Testicular hormone—Primitestone 250 mgm. depot monthly.
(g) Duiretics—Chlorothiazide 1 g. b.d. 5 days a week.

This regime was gradually evolved during the patient's eleven weeks in hospital. During this time chlorothiazide (1 g. b.d.) was administered to relieve the oedema and Imferon (2 c.c. on alternate days × 17) was given to combat the iron deficiency. He also received five pints of blood as his condition deteriorated shortly after admission (albumin 1.9 g/100 ml, H6 44 per cent.). His symptoms of anaemia, oedema, glossitis, dermatitis and neuritis all disappeared. Although his plasma albumin had not risen to normal by the time of discharge it had risen above the critical level below which oedema appeared in this case. He was discharged feeling, as he put it, "Better than I have felt in the last 20 years".

Mr. R. continued on the above regime while leading a normal life and four months later he was still symptom free with one

Clinical Features and Pathological Findings

	Idiopathic Steatorrhoea	Pancreatic Insufficiency	Post-gastrectomy Steatorrhoea (including 'blind-loop' syndrome)	Present case
Past history of Coeliac disease in childhood ..	Usually present	Absent	Absent	Absent
Fat absorption ..	Reduced	Reduced	Reduced	Reduced
Hypoproteinaemia	Variable	Present	Variable (usually absent)	Present
Barium meal X-ray	Flocculation pattern seen	Normal	Usually normal	No flocculation pattern seen
Pancreatic enzymes	Normal	Reduced	Usually normal	Reduced
Glucose absorption	Reduced	Usually normal	Normal	Normal
Starch absorption	Reduced (really due to low glucose absorption)	Reduced (failure to split starch)	Normal	Reduced
B12 absorption ..	Reduced	Normal	Reduced	Reduced
Response to gluten-free diet ..	Usually good	None	None	None
Response to Pancreatin	None	Good	None	Good
Intestinal biopsy	Characteristic atrophy of mucous membrane	Normal	Normal	(Not done)

Table II

normal bowel action per day. The anaemia (Hb then 86 per cent) and hypoproteinaemia (albumin then 4.6 gm/100 ml.) appeared to have resolved completely. The liver function and protein absorption as measured by the pseudocholinesterase level (then 55 units) was improving.

The replacement therapy will be continued for life and Mr. R. will be seen at regular intervals.

Discussion

It was the emminent Bart's physician Dr. Samuel Gee (1888) who gave one of the first authoritative accounts of the clinical picture of steatorrhoea in his classic paper on ' The Coeliac Affection '.

The patient under discussion demonstrated many of the symptoms and signs mentioned by Dr. Gee and since known to occur with the ' malabsorption syndrome '.

Cook (1952) states that 2 per cent of patients who have had a partial gastrectomy suffer from continued steatorrhoea. Cooper (1952) considers that among the possible causes of this, one must include hurry through the gastric remnant resulting in inadequate mixing of food and enzymes, and a possible retention of pancreatic enzymes within the blind loop.

Another factor is that of invasion of the blind loop by organisms not normally found in the upper intestine. Badenoch (1958) in a review of this so-called ' blind loop syndrome ' describes how various vitamin deficiencies may arise. There is possibly a decreased synthesis of vitamins by the normal bacterial flora and an increased utilisation of vitamins

Malabsorption	Clinical Evidence	Pathological Evidence	Remarks
FAT	Frequent, bulky malodorous stools	Total fat excretion in 48 hr.: 89g (normal: less than 6g/day)	Extreme steatorrhoea
PROTEIN	Oedema of legs, hands and face	Muscle fibres in stool Plasma albumin: 2.4g/100ml (normal 4-5.5 g/100 ml)	
ERYTHROPOIETIC FACTORS	Anaemia leading to dyspnoea	Haemoglobin 64% normal	
Iron		Mean Corpuscular Haemoglobin concentration (MCHC): 29% (normal: 32-38%)	
B12		Mean Corpuscular volume (M.C.V.): 110 c.μ. (normal 78-94 c.μ.)	
		Injection of 50 μgm B12 led to a brisk reticulocyte response	Shows marrow could respond to, and was deficient in, B12
		Marrow puncture: cells suggestive of megoloblasts seen	
		Vit. B12 absorption test: low absorption of B12	Radioactive B12 given orally with and without intrinsic factor, and uptake measured
VITAMINS A		Vitamin A absorption test: nil absorbed	This is also a measure of fat absorption
B Group	Glossitis Dermatitis (on shins) Peripheral neuritis (anaesthetic area on legs, muscle tenderness)		A multiple deficiency of B group vitamins
?C	Multiple ecchymoses		
D (+Calcium)		Serum calcium: 8.3 mg/100ml (normal 9-11 mg/100 ml) (Serum inorganic phosphorous 2.8 mg/100 ml—normal: 2.5-4 mg/100 ml)	

(There was no evidence of malabsorption of vitamin K. The prothrombin time was normal)

Table III

by the abnormal inhabitants. In this condition there is always a multiple vitamin deficiency, as seen in the present case.

The patient, however, also had evidence of pancreatic damage. According to Frazer (1952) pancreatic lipase is essential for the complete absorption of fat. Any reduction of this enzyme would lead to a decreased fat absorption with a secondary reduction in the absorption of fat-soluble vitamins (A, D, K, and E).

The oedema seen in this case, which at one stage was very extensive, was due almost entirely to a low plasma albumin level. Albumin is the main constituent of the plasma which ensures osmotic reabsorption of fluid from the tissues into the circulation at the venous end of the capillaries. When the level of albumin falls, this reabsorption does not take place. Adlersberg (1957) suggests that the low albumin level might be secondary to one of the following: impaired nutrition; decreased absorption of protein; impaired liver synthesis. It is likely that decreased protein absorption due to reduced pancreatic trypsin was the main factor in the present case.

Anaemia is a frequent finding in the malabsorption syndrome. In most cases it is due to a failure of vitamin B12 absorption, as seen in the patient under discussion.

The case which has been presented above illustrates how the intestine may fail to cope with its allotted tasks, a state which might be covered by the term 'intestinal failure'. At present the working of the intestine both in health and disease remains largely unknown, and the diagnosis of the cause of any case of intestinal failure will rest mainly on evidence supplied by the pathologists.

Acknowledgments

I should like to thank Dr. Griffth Edwards for his considerable help in the presentation of this paper. I am grateful to Dr. G. W. Hayward for permission to publish the case and for the interest he has shown in its preparation.

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PSEUDO-ANGINA PECTORIS

A Forgotten Chapter of Medicine

by **R. D. MARSHALL**

(The title and incentive for the research were provided by Dr. E. B. Strauss)

Angina Pectoris is a syndrome with which we must all be conversant omit from the introductory course to the end of our careers (and, if we are to believe medical statistics, a syndrome from which a considerable number of us will in time suffer). The well recognised differential diagnosis is a syndrome which has been denoted by numerous terms, of which Effort Syndrome, Soldier's Heart and Neurocirculatory Asthenia are the most commonly used. Typical cases of true angina at one end of the scale and typical cases of neurocirculatory asthenia at the other end of the scale are easily recognisable, but there are many intermediate grades of atypical angina, some of which are wrongly diagnosed and some of these are most likely due to excessive upper thoracic breathing.

True Angina Pectoris

This may be defined as a syndrome consisting of paroxysmal substernal or precordial pain, frequently radiating to the shoulders and inner aspects of the arms. The pain is

usually precipitated by exertion or other states in which the work of the heart is increased. The pain is relieved by rest or trinitroglycerine.

The cause of the pain is myocardial ischaemia, in that the blood supply is deficient in relation to the requirements of the myocardium to accomplish its work. Approximately 90% of cases are due to atheroma of the coronary arteries with or without subsequent thrombosis; whilst hypertension, valvular disease, syphylitic aortitis, Buerger's disease and other rare conditions account for the remaining 10%.

Neurocirculatory Asthenia

This condition has a multitude of names. It was first described by Da Costa who noted it as a clinical entity in soldiers; he termed it Soldier's Heart. The condition has also been called Effort Syndrome and Disordered Action of the Heart (which means very little, but sounds very learned). It is now considered to be a psychoneurosis with cardiovascular symptons but the precise aetiology is unknown.

The condition may be defined as a functional disorder of the vasomotor system characterised by fatigue, dyspnoea, palpitations and precordial pain. It is often exhibited by the asthenic type of person when under stress and is most common in the 2nd, 3rd and 4th decades.

The pain is sharp and stabbing and may be associated with an area of tenderness at the position of the apex beat. Patients usually complain of a persistent substernal ache unrelated to exertion. There is often a past or family history of psychoneurosis.

Treatment consists of psychotherapy or removal of the patient from the situation in which the illness occurred—such as discharge from the army. Temporary or permanent cure may be obtained in about 40 % of cases. No one ever dies from neurocirculatory asthenia.

Pseudo Angina

For the purpose of the article, this may be defined as an anginal type of pain due to excessive upper thoracic excursions.

Sir Charlton Briscoe writes in the *Lancet* in 1922 (The Anginal Syndrome. *Lancet* 1922, ii, 1257).

" I have been constantly testing the actions of the accessory muscles concerned in respiration . . . what I found was as follows.

"Some of these accessory muscles varied very much in intensity of action and stress in different portions of the body and in different circumstances.

" When under stress, these muscles became tender and . . . when pressure was made upon these tender muscles, the pain produced was not always a mere local sensation, but was referred to wide areas very similar to those concerned in angina pectoris.

"Next I found that in some cases which had suffered from an anginal type of pain, pressure on certain of these muscles produced pain similar to that of the attack.

"In some cases of angina relief of tension in these muscles was followed by cessation of the pain".

There are various precipitating causes of this type of angina and the main ones are:

1. Physical strain and exertion.
2. Emotion.
3. Large meals, when the dilated stomach produces elevation of the diaphragm.
4. Pneumonia and similar pathological conditions in which the bases of the lungs lose their function.
5. Adoption of the supine posture, as in prolonged bed rest brought about by debilitating conditions.

All these factors may produce overwork of the upper thoracic mechanism, and as a result produce fatigue and tension of the muscles concerned. The precipitating factors which I have listed may also lead to true angina pectoris and as a result make the differential diagnosis difficult; but in anginal pain due to fatigue and tension of the affected muscles, pressure on these muscles will produce a characteristic attack.

The muscles principally concerned are the scalenes, the upper 4-6 intercostals and the triangularis sterni. It is certain that these muscles may be temporarily overworked in excessive upper thoracic excursions and that they tend to become tender to pressure. When the strain is removed the tenderness disappears and they rapidly recover. Pressure on the muscles not only produces localised pain, but also referred pain. This may be referred to the sternum, shoulder, axillae, inner and outer arms (mainly on the left side). The referred pain may obviously be readily confused with true angina pectoris due to myocardial ischaemia.

Treatment by alleviating the stress of these muscles has frequently been effective in relieving the pain without any other therapy.

11th DECENNIAL CLUB

The twenty-fourth Dinner of the Eleventh Decennial Club (those joining the hospital between January, 1915, and December, 1925, who afterwards qualified), will be held at Simpson's-in-the-Strand on Friday, April 17th, at 7 for 7.30 p.m. Mr. J. W. D. Buttery will be in the Chair. Notice will be sent to all members whose address is available, and a reply would be much appreciated by the Hon. Secretaries, even if you are not coming, so that your address can be verified. So many do not respond that they feel that many of the cards fail to reach their destination, and printing and postage are too costly to waste. Those who have never joined are still welcome, and should communicate with F. C. W. Capps, 16 Park Square East, N.W.1.

Story from a Transatlantic Correspondent

A girl walked up to the desk of a hospital and said " I'd like to see an upturn."

" Don't you mean an intern ? " asked the nurse.

" I guess so, I want an contamination".

" You mean an examination", queried the nurse.

" I guess so. I want to go to the fraternity ward".

" You mean the maternity ward, my dear", replied the nurse.

To which the girl loudly retorted: " Upturn, intern, contamination, examination, fraternity, maternity . . . what the hell's the difference—all I know is that I have not demonstrated for two months and I think I'm stagnant".

LETTERS TO THE EDITOR

Dear Sir,

Dr. Thorn's letter in the January issue of the Journal on what has now come to be called the student attachment scheme is very welcome and I would support it wholeheartedly.

May I take this opportunity as Dr. Abercrombie's successor to say a little more about the work of the Adviser in General Practice? This was a new post instituted by the Medical College a year ago to develop a liaison between students and general practice.

The Adviser attends the College every Tuesday morning and is available in the Dean's office to give advice on general practice to any student or old Barts' man and to arrange any form of co-operation with general practitioners.

The student attachment scheme (a short period of attachment to established general practitioners) is now available. It is of value to the student before qualification in allowing him to see the many aspects and problems of general practice he will not meet in a medical school; to the graduate in his pre-registration year as a means of helping him to prepare for his future work and to the newly registered as a means of seeing the type of practice he may wish to enter before he commits himself. A number of men and women have taken the opportunity of " trying " general practice in this way immediately after " finals " while waiting to obtain their first pre-registration post. General practitioners welcome their newly qualified colleagues at this time.

Constant enquiries are being made by old Barts' men and others for assistants, trainee assistants and locum tenens which may lead to entry into excellent practices. Most of these are advertised on the notice board and details are available in the Sub-Dean's Office. Those in search of a post should not forget that there may be something to suit them waiting on the files.

Lastly, any suggestions or ideas for solving the problems related to medical education and general practice are very welcome.

T. O. McKANE.
Adviser in General Practice
Tel: Gt. Dunmow 5
Gt. Easton 263

High St.,
Dunmow, Essex.

Dear Sir,

I feel that G.F.A.'s critque of the Christmas Shows in the last Journal is incomplete. His task is not enviable; English temperament becomes quite Latin when it comes to who gets into the Pot Pourri, but in giving credit for the entertainment (although happily remembering the pianists) he does not give the producers a mention.

Surely most of the credit for a good ward show should go to the producer. It may happen that he is blessed with a talented cast, perhaps even able to produce their own lyrics, but it is still *his burden* to get them to rehearse, to learn their lines, to enthuse, and to keep them alert for their cues during the show.

If the House was best this year, it was because they were fortunate enough to have a musical genius to arrange the songs and drill the part singers, and a really experienced producer who could plan a show with no pauses, put polish on the smaller acts, and mould a massive chorus which never attended any one rehearsal complete.

This point was made about three years ago; may we next year again see the producers awarded their Oscars by your reporters.

Yours faithfully

COCCYX.

ED.—*We entirely agree with Mr. Coccyx. It was an omission not to praise the producers. Nor did we this year include an account of the Pot-Pourri, so we did not praise Mr. Trevor Robinson and all the*

others concerned with producing a polished revue from a real pot-pourri of acts and numbers. Again they thoroughly deserve our retrospective congratulations and admiration.

SPORTS NEWS

VIEWPOINT

It has been suggested that the conduct of medical students at interhospital rugger ties leaves much to be desired, in view of the fact that they are to become some of the most responsible members of the community.

Being thus stimulated one wishes to find out on what these allegations are based and in doing so what makes this generation so different from those valued and respected members of the profession who have preceded us in this preliminary party their medical endeavour. Are we to surmise that long faces and frock coats were the order of the day. That one's appreciation of the game was marked by an occasional outburst of applause or half-hearted cheers and even one's partisan feelings cloaked under a guise ' good afternoon ' ? Such an outlook would have been as much deplored then as now. Indeed one may go further and reiterate, as it were in retrospect, that while this country continues to produce the highest standard of medicine in the world, there would appear to be no cause for alarm.

RUGBY

United Hospitals Rugby Cup. Barts v Guys. At Richmond. January 20th. 2nd Round. Barts won 6-0.

Barts drew Guys in the second round of the competition, both teams having drawn a bye in the first. Thus by their win Barts qualified to meet St. Thomas', the holders in the semi-final.

Guys were last years losing finalists and Barts did well to overcome them so convincingly. Indeed the final score of 6-0 hardly flattered the victors at all. The match was preceded by a cloudburst. lasting a quarter of an hour and turning the pitch nearly into a quagmire. The pattern of the game was therefor in no doubt before the play began: quick rushes by the forwards alternating with kicking for touch outside. Such it proved to be.

The Barts forwards did their job magnificently. They were up against a heavier pack and gave nothing away in the fight at all: indeed on one memorable occasion they all but scored a push over try. in the lineouts L. R. Thomas and Boladz gave Barts a distinct advantage with a fine display, out jumping taller men. But it was in the loose the forwards excelled. Inspired by their leader Hamilton, and not a little one imagines from the vocal support on the touchline they rushed over the field like men possessed. The opposition stood no chance of keeping up that pace, and inspite of relieving kicks, Barts were invariably pressing.

Outside the halves Richards and Rees Davies struck up a good partnership which the latter's kicking to become a powerful force. The backs in the conditions could not really expect to see a lot of the ball and one should reserve judgment for a day more suited to their play. At full back initial anxiety was soon relieved as Ross's positioning and kicking improved manifestly.

There was no score in the first half although Barts had come very close on two occasions. Once as already mentioned nearly scoring a pushover try and the other from a quick attack following a drop out: Smith the wing was eventually just beaten for the touch down by the ball being kicked out in goal.

The second half saw Barts really come into their own and they were consistently pressing. It therefore seemed scant justice when a fine burst by Rees Davies following a set scrum on the Guys Twenty-five broke through the defence and his pass straight to the wing half was beautifully timed for the latter to race over in the corner. The kick by Stevens just failed, hitting the cross bar and falling back.

Guys were repeatedly saved by the sound positioning and kicking of their full back. However eventually they gave away a penalty just inside their twenty-five from which Rees Davies' kick went straight over. That was for Guys the final nail in their coffin. One hopes that the combination of skill and zest seen in this match will take Barts further, against tougher opposition.

Team: A. P. Ross; R. Smith, J. Stevens, M. Britz, G. J. Halls; R. R. Davies, B. Richards; B. O. Thomas, J. W. Hamilton (capt.) B. Lofts; L. R. Thomas, W. P. Boladz; R. P. Davies, D. A. Richards, J. C. Mackenzie.

Barts v. O. Rutlishians. Saturday, January 3rd. Won 11-3.

Barts beat the Old Rutlishians at Chislehurst by a goal, a try and a penalty to a penalty goal.

Both sides were rather slow starting and during the first half neither side looked like scoring.

After the interval Barts were awarded a penalty and Pennington put Barts in the lead with a prodigious kick from the touchline. Soon after this the Old Rutlishians retaliated with a successful penalty kick.

It was then that Barts began to show their superiority. A stray pass by a Rutlishian centre was snapped up by Stevens who ran down the middle before passing the ball to left wing Halls. After beating his man he cut inside and the movement ended with B. O. Thomas crashing over to score under the posts. The try was goaled by Pennington.

The next try was the result of a short penalty

taken near the Old Boys' line when a scissors movement sent the ball to Lofts who scored well out.

The game ended with the Rutlishians pressing hard but unable to pierce the Barts defence.

Team: A. P. Ross; I. R. Smith, J. Stevens, A. B. M. McMaster, G. J. Halls; R. R. Davies, W. H. C. Berry; B. O. Thomas, J. W. Hamilton (Capt.), B. Lofts; J. H. Pennington, W. P. Boladz; R. P. Davies, D. A. Richards, G. H. Randle.

Barts v Taunton. Saturday, January 10th. Away—lost 3-14.

Barts lost at Taunton by a goal, a penalty and two tries to a penalty goal. The game was played on a hard frozen ground against a strong Taunton side.

The Barts forwards had an off day in that they were slow to fall on the ball and failed to gain possession in the majority of the lineouts where they usually fare so well.

Taunton had fast-running elusive backs and they were able to break through the shaky Barts defence. At full-back Ross could not control the awkwardly bouncing ball and was tested time and time again by well judged diagonal kicks by the experienced Taunton fly half.

Pennington scored for Barts with a well kicked penalty.

Team: A. P. Ross; I. R. Smith, A. T. Letchworth, J. Stevens, G. J. Halls; R. R. Davies; W. H. C. Berry; B. O. Thomas, J. W. Thomas, J. W. Hamilton (Capt.), B. Lofts, J. H. Pennington, M. Harries, R. P. Davies, L. R. Thomas, G. H. Randle.

Saturday 17th. Barts *v* Cheltenham—away. Cancelled—ground unfit.

1st XV v Old Millhillians. Sat. 24th Jan. Lost 3-19.

This game was transferred to Chislehurst as the Old Millhillians ground was waterlogged. Barts in this match sustained their heaviest loss of the season, which was all the more surprising after their fine victory over Guys earlier in the week. The Old Millhillians are a strong side and Barts would do well to beat them.

Barts showed two changes from the victorious cup team, both centres having dropped out through injury. A further tragedy was soon to occur early on in the game when Rees Davies sustained a nasty kick on the head which forced him to leave the field. At that time the opposition was leading by a penalty goal. However, on a lovely fine day, with firm ground and fast moving backs we were unable to hold the opposition; time and time again they were through only to be denied scoring by last-minute tackling and kicking. The forwards, as always, did a fine job and earlier on were on top, but as was to be expected, being one short they tired later in the second half.

From the Old Millhillians we saw some fine breaks from the base of the scrum by J. E. Williams, two of which led to tries and also just before no side a lovely run by J. Roberts on the wing to score wide out. Altogether 2 goals, 2 tries, and a penalty goal were scored against, with Barts solitary reply of a penalty goal kicked by G. J. Hells.

Team: A. P. Ross, G. J. Halls; J. C. Owens, J. K. Bamford, R. Smith; R. R. Davies, B. Richards; B. O. Thomas, J. W. Hamilton (Capt.), B. Crofts; L. R. Thomas, W. P. Boladz; R. P. Davies, D. A. Richards, J. C. Mackenzie.

Saturday 31st. Barts *v* Rugby—away. Cancelled—ground unfit.

ROWING

A composite scratch crew was entered for the junior division of the University of London Winter Eights at Chiswick on December 6th. It had proved impossible to have an outing before the day owing to illness, but on the day however the crew raced hard and were unfortunate to lose their fourth race when nearly overcome by exhaustion.

The first race resulted in a dead heat with Birkbeck College after Barts had been misinformed about the position of the finishing post. In a rerow Birkbeck fouled Barts and were disqualified. In their next race Barts were to row against Westminster Hospital but at the last minute a University College crew was also included. The race resulted in a clash of oars between ourselves and U.C. and owing to the impaired vision of the umpire a rerow was ordered. As hinted above the crew were now very tired and were unable to hold the well-trained University College crew and lost by half a length.

Crew: Bow—J. L. Lewis; 2, I.Wai Ping; 3, J. J. D. Bartlett; 4, P. W. A. Mansell; 5, H. M. B. Busfield; 6, R. S. Edmondson; 7, J. R. H. Fisher; Str., W. S. Shand. Cox—J. U. Watson.

RIFLE CLUB

During the small-bore season, extending from October to March, the Rifle Club is entering eight teams in competitions in United Hospital, London University and N.S.R.A. Leagues. This entails firing 67 postal matches in addition to shoulder to shoulder friendly matches. Here is the position at roughly half-way.

United Hospitals Lloyd Cup

The 'A' team has won 3 out of 4 matches, and the 'B' team, 2 out of 4.

Tyro Competition

The 'A' team has won 2 out of 3, and the 'B' team 1 out of 2.

London University Leagues

Pistol—The 'A' team, having won the 2nd division last year, has met much stiffer opposition this year in the 1st division. Out of 6 matches they have won 1.

The 'B' team has only lost one match, by a margin of 2 points and leads the division with a margin of 200 points.

Standing and Kneeling.—The team is lying second in the division, having won 4 out of 5 matches.

N.S.R.A. Standing and Kneeling.—The team is first in its division, having won all its matches by some 200 points.

The Club has over 40 membes, five of whom have shot for United Hospitals this season.

SOCCER

1st XI v. St. George's Hospital. December 3rd. Away—won 2-0.

In many ways this was the most successful match played so far. Our opponents were a strong and established hospital side, whereas we fielded a team that included several new players and few of the veterans. As a result it was a good omen for the future.

Barts soon mastered the slippery condition of the pitch and with the forwards moving the ball well we were constantly in the attack. First blood came when a long ball down the middle sent Savage away and he scored with professional coolness. Fortunately luck was on our side and twice our goalkeeper cleared with impromptu kicks off the line in the face of oncoming forwards.

In defence Gletsu was outstanding with his fierce tackling which did much to discourage the opposition. The forwards pressed hard on the George's defence and forced several corners. From one of these we took our second goal. Downer, the right wing, calmly trapped and lobbed the ball past a helpless goalkeeper. Prosser and Juniper firmly countered late attacks into our half and at the final whistle we were deservedly two goals in the lead.

As we left the field the referee was heard to say it was the first time he had seen Barts play real football. Praise indeed!

Team: M. Fogarty; D. Prosser, A. Gletsu; R. Kennedy, C. Juniper, B. Perris; I. Downer, B. Hore, P. Savage, H. Phillips, M. Noble.

SAILING CLUB

Welsh Harp Winter Series

October 22nd. 6th.
D. Welch, helm
D. Colin-Jones, crew.

November 5th. 5th.
R. C. Birt, helm.
Miss F. E. Rose, crew.

November 19th. 6th.
W. G. Fischer, helm.
R. C. Birt, crew.

December 3rd. 7th.
D. Colin-Jones, helm.
A. J. Balfour, crew.

WOMEN'S HOCKEY

1st XI v. University College, London. Lost—4-0.

A rather depleted 1st XI played their first match for six weeks, on a damp pitch in continuous rain. The team naturally lacked co-ordination, especially in the forward line, but J. Swallow and S. Minns worked hard and played well together on the left and had many near misses at goal. The defence worked hard, but the backs tended to play too square making it easier for the opposing forwards to penetrate, although they were often stopped because of offside. M. Childe and J. Hall were quick onto the ball, and gave good passes to their forwards.

Team: I Tomkins (Capt.); S. Cotten, T. Coates; M. Childe, J. Hall, M. Robertson; V. Nash, P. Smyth, R. Benison, S. Minns, J. Swallow.

EXAMINATION SUCCESSES

UNIVERSITY OF OXFORD

Second B.M. Examination. Michaelmas Term 1958

Pass

Chong, J. K. K.-H.
Cook, R. C.
McMaster, A. B. M.
Price, J. S.
Silverstone, J. T.
Smith, R. G. L.
Wells, D. P.

UNIVERSITY OF CAMBRIDGE

Final M.B. Examination. Michaelmas Term 1958

Pass

Campbell, A. J P.
MacAdam, D. B.
Matthews, T. S.
Rhys-Phillips, D.
Ridsdill-Smith, R. M.
Robinson, T. W. E.
Roles, N. C.
Simons, R. M.
Strong, J R.

Supplementary Pass List

Part I. Pathology and Pharmacology

Abercrombie, G. F.
Bowles, K. R.
Cantrell, E. G.
Davies, R. N.
Dick, D. H.
Drinkwater, P.
Duff, T. B.
Evans, G. H.
Francis, H. B.
Hamilton, S. G. I.
Hindson, T. C.
Hobday, J. D.

Hurding, R. F.
Mather, J. S.
Richards, D. A.
Williamson, C. J. F. L.
Jephcott, C. J. A.
Parkes, J. D.
Strang, F. A.
Lee, B. K.
Perkins, B. A. W.
Tooth, J. S. H.

Part II. Medicine
Boston, F. M.
Faber, V. C.
Haslam, M. T.

Part II. Surgery

Part II. Midwifery
Faber, V. C.
Haslam, M. T.
Tooth, J. S. H.

UNIVERSITY OF LONDON

M.Sc. Examination. November 1958

Dimoline, A. (Biochemistry)

Ph.D. Examination. November 1958

Lovell, S. (Faculty of Science)
Harries, E. H. L. (Faculty of Medicine)

Special First Examination for Medical Degrees. December 1958

Pass
Nash, A. V.
Pope, F. B.

The following General Certificate of Education Candidates have qualified for exemption from the First Medical:
Abayomi, I. O.
Davies, W. A. M.
Gardiner, S. P.
Miller, A. J.
Sewell, J. B.
Whitaker, S. M.
Benison, R. S.
Fisher, R. G.
Lloyd, C. M.
Morris, J.
Stephens, K. MacG.
Ying, I. A.
Brewer, C. L.
Frank, A. J. M.
McLaughlin, J. E.
Pitt, J. M.
Walker, H. R. J.

CONJOINT BOARD

First Examination. December 1958

Pharmacology
Fox, G. C.
Arnold, J.
Musgrove, J. S.
Robinson, J. S.
Barraclough, G. P. M.
Cassell, P. G.
Durrant, K. R.
Goodchild, M. C.
Almeyda, J. J. R.
Milburn, F. A.
Booth, D.
Pettavel, J. P.
Dobson, J. L. C.
Vollum, D. I.

CONJOINT BOARD

Final Examination — January 1959

Pathology
Faber, V. C.
Patterson, M. J. L.
Dymond, G. S.
Evans, G. H.
Marshall, R. D.
Peebles, D. J.
Woolmore, M. J. F.
Robinson, T. W. E.
Dobson, J. L. C.
Gabriel, R. W.
Mather, J. S.
Williamson, C. J. F L.
Thompson A. J.
Bowles, K. R.
Davies, R. N.
Hobday, J. D.
Perkins, B. A. W.

Medicine
Faber, V. C.
Warrander, A.
Gould, A. M.
Woolmore, M. J. F.
Lewis, J. H.
Patterson, M. J. L.

Surgery
Robinson, T. W. E.

Midwifery
Robinson, T. W. E.
Haslam, M. T.

The following have completed the examinations for the Diploma:
Robinson, T. W. E.
Haslam, M. T.

ROYAL COLLEGE OF SURGEONS

Final F.R.C.S. November 1958

Dawson, D. A. (In Otolaryngology)
Ffooks, O. O. F. (In Ophthalmology)
Collymore, H. W. M.
Bower, D. B.

Primary Fellowship, Faculty of Anaesthetists. December 1958

Hamilton, L. A. T. Jepson, B. A. Willis, P. F.

THE CHOICE OF A TEXTBOOK OF SURGERY

by a **BART'S SURGEON**

The present time will perhaps in years to come be known as the golden age of the author of students' surgical text books. At no time before can the student have had such a wide selection of books and such an impossible choice to make. Not only from home indeed, but also from across the Atlantic, constant salvos of students' text books on surgery have landed on our shores during the last few years.

In some ways the American text books are very good, but in general only parts of them are of value to the British student. This is because they are written for quite a different type of surgical teaching. For the one-book man they have no place. However, to the wider reader parts which deal with physiological principles which is the " new book " in surgery are useful and instructive. Such a book is Harkins, Moyer, Allen and Rhoads.

When we are asked by students to advise them on the choice of surgical text books, which to buy, which to read and which to avoid, we must first examine the place of a students' text book in the British method of surgical teaching.

The text book written by a single author has virtually gone with the growth of surgery and the increase in specialisation. Most of the modern books are a composite effort. Such a book may cease to be a text book in the old sense of the word and become no more than a series of compressed monographs collected between two covers.

We must ask ourselves, do students really learn surgery from books? Personally, I doubt it—at least I do not think that they can learn the things that make them reliable and safe doctors. This last, I think, can still only be obtained by good bedside teaching and seeing and personally examining patients, together with reading.

In this regime, the students text book acts as a scaffolding for his clinical teaching and fills in the gaps. It should be a guide rather than an encyclopaedia, a survey map rather than a gazetteer.

I would suggest that what the student requires in his text book is a moderately sized and priced volume which he can read as a companion to his clinical teaching. For some things in the specialities this book will not be full enough and this need can be easily met by the hospital library keeping an up to date supply of the many excellent specialist books.

If on the other hand the authors of a students' text book attempt to provide him with " all he could want in surgery " between two covers, the task is enormous and the resulting volume of the same proportions. Again the changing face of modern surgery will make constant revision of such a book necessary. This is costly in author's time and a bad proposition for the student who finds after no more than two years that his large and expensive book on surgery is out of date and without second hand value.

One wonders how this problem is to be solved and clearly this is of special importance to those who are interested in student education. I venture to suggest that one way would be to have a choice of two or three basic texts dealing with general principles, the bulk of which would not greatly change with time and could remain a book of reference for the

doctors' bookshelf. If this was combined with some sort of year book on the lines of the B.M.J. refresher courses, the student could read this to gain the most recent information and might continue to buy and read them throughout his professional career. This would not limit authorship but rather increase it at the same time perhaps putting it to the best use.

For the most part the majority of British texts come into the category of good books. To single out one book from its fellows with this high standard is not easy, unless it possesses above all the essential qualities plus something which the others lack and therefore fills a real need for the student.

Of the standard British texts for students the following are in common use and are listed below.

If we could give any advice, and it is difficult to do so, we would suggest that before deciding on one book you look at the others too.

The following is a library list of some of the available textbooks of general surgery. It should help the student to know the field open to him, though it is not comprehensive and does not include works in the special branches.

AIRD, I. A companion to surgical studies, 2nd ed., 1957.

BAILEY, H. Demonstrations of physical signs in clinial surgery. 12th ed. 1954.

BAILEY, H., and LOVE, R. J. McN. A short practice of surgery, 11th ed., 1958.

BLACKBURN, G., and LAWRIE, R. Textbook of surgery, 1958.

EDWARDS, H. C. Recent advances in surgery. 4th ed., 1954.

FARQUHARSON, E. L. Illustrations of surgical treatment, instruments and appliances, 4th ed.

HANDFIELD-JONES, R. M., and PORRITT, SIR ARTHUR. The essentials of modern surgery, 5th ed., 1957.

ILLINGWORTH, C. F. W. A short text book of surgery, 6th ed., 1955.

KIELY, P. Textbook of surgery, 2nd ed., 1958.

LEDLIE, R. C. B., and HARMER, M. Aids to Surgery, 8th ed., 1952.

OLIVER, L. C. Basic surgery, 1958.

PATEY, D. H. Introduction to surgery.

PYE'S Surgical handicraft. 17th ed., edited by Hamilton Bailey, 1956.

SAINT, C. F. M. Surgical note-taking, 4th ed., 1947.

BOOK REVIEWS

A SHORT PRACTICE OF SURGERY. 11th Edition by Hamilton Bailey, F.R.C.S., (Eng.), F.A.C.S., F.I.C.S., F.R.S.E., McNeill Love, M.S.(Lond), F.R.C.S. (Eng.), F.A.C.S., F.I.C.S. and others. pp. 1389 + xii, 1697 illustration (285 coloured). Price £4 4*s*.

This new edition of Bailey and Love's well-known textbook of surgery is 260 pages longer than the previous one. It has 286 more illustrations (including 541 new ones) and retains its former price of 4 gns.

The authors have largely rewritten the chapters dealing with the thyroid, ductless glands, the liver, and the stomach, and there are two completely new chapters, one on Fluid and Electrolyte balance, and one on Radiotherapy. Both of these latter are to be welcomed, and present a good brief account of their subjects.

The layout and presentation are very similar to the previous edition, and the greater length seems to be the result of greater elaboration. For instance there are now 15 causes of goitre given, whereas there were only 11 two years ago. (" Lymphadenoid " and Riedel's thyroiditis are promoted—though Riedel is mis-spelt on p. 243.)

The index is somewhat selective. Intermittent claudication is not in it, though Chiari's syndrome is. Arteriosclerosis is only to be found in connection with pancreatitis! In general the surgical outlook on arteries is not well treated in this book. Part is under the sympathetic system and the rest is nearly 900 pages away under blood vessels. Nor is it just to introduce a new paragraph on arteriography, while retaining only one obsolete method of arterial grafting and an obsolete explanation of idiopathic lymphoedema. While it is very difficult for a new edition of an old textbook to keep up with all new advances in specialized branches of the subject, it is nevertheless a pity when it doesn't. There is far more, however, to praise than to criticize in this textbook. Surgery is very clearly presented, factual and accurate. It is by no means short but the authors are to be warmly congratulated on again producing a textbook which gives every aid to the student not only to know his surgery, but to be able to pass his exams.

It is not entirely without humour, either, fig. 798 is titled " The musculature of the anal canal (After Naunton Morgan) " and fig. 799 is titled " The lining membrane of the anal canal (Inspired by Naunton Morgan)."

J.D.S.

ROXBURGH'S COMMON SKIN DISEASES. 11th Edition revised by P. F. Borrie. pp. xxiv + 496. Illus. 215, 8 coloured plates. Price £1 17*s*. 6*d*.

The 11th edition of this famous textbook is the

first new addition to appear since Dr. Roxburgh's death in 1955, and the revision has been done by Dr. Borrie with care and skill.

Roxburgh's Common Skin Diseases is well known for its clear and concise descriptions of the common skin lesions and for the practical treatment of these disorders. Very few changes have been made in the passages concerned with description and diagnosis. However the section on varicose veins has been largely rewritten and changes have been made in the sections dealing with the aetiology of Rosacea, Lupus erythematosus and Erythema nodosum. In addition, the chapter on syphilis has been completely rewritten and re-illustrated giving a more concise and up-to-date account of the skin lesions of this rapidly disappearing disease.

It is in the treatment of skin disorders that most alterations have been made. The advent of new antibiotics such as neomycin and nystatin has made the treatments of skin infections more certain and specific. In the treatment of lupus vulgaris and tuberculides isoniazid and streptomycin have now replaced calciferol therapy and local excision giving a much better prognosis for the disease; and hydrocortisone is now extensively used for suppressing eczema and dermatitis. But despite these modern drugs many methods of treatment are still palliative rather than curative.

The book is well designed and is illustrated by over 200 excellent photographs. Dr. Borrie has amply maintained the high standard set him and this book can be recommended for student and practitioner alike.

J.E.C.

A HISTORY OF MEDICINE. Douglas Guthrie. With supplement. **London,** (*etc.*), **Thomas Nelson.** 1958. 463 pp., 42*s*.

The publisher's blurb advertising this book states that " the text has been thoroughly revised throughout to include the results of recent research and discovery," and talks of " the new edition, with its throughly up-to-date information." Neither the title-page nor the spine of the book state that this is a second edition, and in fact it is another page-for-page reprint with the addition of a few extra references, mainly at the ends of chapters, and a brief supplement, the contents of which are not included in the index. The supplementary material is not confined to recently published information.

Dr. Guthrie's *History of Medicine* has been widely appreciated as a popular introduction to the subject, but it was hoped that a new edition would be thoroughly revised, and cater for more advanced students. The preface to the first edition, here reproduced, states: " nor is there any British periodical devoted to this aspect of medicine." *Medical History* began publication two years ago, and much work on medical history has been accomplished since 1945, as evidenced by *Current Work in the History of Medicine* published quarterly by the Wellcome Historical Medical Library. In

this new edition we do not even find mention of the volumes of Munk's *Roll*, published in 1955, or of Plarr's *Lives*, which appeared in 1953, and far too many footnotes still refer to secondary, obsolete sources.

The publishers should have encouraged Dr. Guthrie thoroughly to revise the text, for it has previously been reprinted on three occasions, and a second edition revised in the light of current research would not have been widely welcomed. No library or individual possessing the first edition of this book need acquire this reprint, which is merely patched up by the author in a manner permitting the use of the original type. The illustrations are also from the same blocks, but the price is increased by twelve shillings.

J.L.T.

YOUNG ENDEAVOUR: Contributions to science by medical students of the past four centuries. By William Carleton Gibson. With a foreword by Sir Henry Dale. Springfield, Ill., Charles C. Thomas. (Oxford, Blackwell). (1958) xx, 292 pp. 50*s*.

Those who have read Professor Gibson's previous articles on the subject will welcome this greatly expanded version, which ranges over the entire field of medicine. Chapters are devoted to specific subjects, and within these the authors are dealt with in chronological order. One is astonished at the number of distinguished scientists who made significant contributions to science while still medical students, and in this book one finds details of their entire careers. Among the anatomists we find Vesalius, Meckel, Gray, Huxley, and Lister; chemistry is honoured by Joseph Black, Paul Ehrlich, Sir Frederick Gowland Hopkins, among others; other subjects are similarly star-studded.

One is impressed by the number of medical students who showed promise at an early age, and, receiving encouragement by their teachers, became eminent in later life. Are students of today given too little assistance to pursue research, or should they concentrate entirely upon text books specimens and lectures in order to qualify as soon as possible? Would it not be better to foster an interest in research, and encourage independent thought, rather than to produce stereotyped medical men? Possibly this book will suggest answers. It is useless if it stimulates students to attempt to emulate the giants of the past, when facilities for doing so are denied them.

The author has the irritating habit of including quotations on separate pages throughout the text, and has also placed all the references at the end of the book, grouped by subject. These would have been more welcome at the ends of chapters, or as footnotes.

This book will be appreciated by all interested in the history of medicine, and medical students in particular should be inspired by the examples presented. There remain many discoveries to be made, and they will not all result from a lifetime of study. Three Bart's men are included in this collec-

tion, Alfred Smee (1818-1877), Sir James Paget (1814-1899), and Thomas Young (1773-1829).

J.L.T.

THE NURSING AND MANAGEMENT OF SKIN DISEASES. By D. S. Wilkinson, M.D., M.R.C.P.

This is an excellent handbook for nurses and family physicians who have to deal with the day-by-day management of the commonly encountered skin disorders.

The author has divided the book into sections—the first of which gives a clear explanation of the anatomy and physiology of normal and abnormal skin—thereby introducing an understanding of both the skin's behaviour and in consequence of the necessary methods of treatment.

A careful discussion of the psychological and sociological aspects of skin disorders emphasises their importance to the family doctor and district nurse who can so easily achieve excellent results—solely from their influence in these spheres.

Another section deals briefly with the main illnesses encountered and most of the remainder of the text is concerned with therapy. Here, good photography and simple descriptions may be easily remembered by the reader who is also given hints to make easier the more complicated procedures.

Finally an appendix gives in detail the various materials and instruments required for routine procedures.

In all the book is a most usefully practical one of its kind.

D. Lowe.

PERIPHERAL NERVE INJURIES. By Ruth E. M. Bowden. **Published b- H. K. Lewis & Co. Ltd.** pp. 62. 8*s*. 6*d*.

The claims of this book to be " An introduction to methods of diagnosis and treatment of nerve injuries " and " designed to meet the needs of physiotherapists, medical students and housemen " are justified. This short book provides an instructive and enjoyable evening's reading. All the thirty illustrations are large enough and very clearly presented. Chapter 4 (anatomy) could have been placed as chapter 2. At the end of the book there are five suggestions for further reading and a very adequate index for a book of this size. In summary this new book is a welcome addition to the shelves of medical literature.

A DOCTOR'S STORY. By Victor Henrikson. pp. 208. Published by Michael Joseph Ltd. Price 18s.

This is the " auto-biography " of a Swedish doctor the ' blurb ' on the cover says " He discusses various aspects of the medical man's life: the terrors of the first operation; the ugliness of professional jealousy; the fear of being sued for negligence; the mental torment that physicians and surgeons undergo when they ask themselves if they are doing the right thing, the burden of their responsibility and the dread of making an irremedial mistake—he has been on the staff of a number of hospitals, has been a country practitioner, an army doctor, a psychiatrist and an eye surgeon."

In other words the book has been written for the impressionable layman.